



# IOWA POPULATION HEALTH ROADMAP

State Innovation Model

March 1, 2017

# IOWA ROADMAP TO IMPROVE POPULATION HEALTH

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# IOWA ROADMAP TO IMPROVE POPULATION HEALTH

## INTRODUCTION

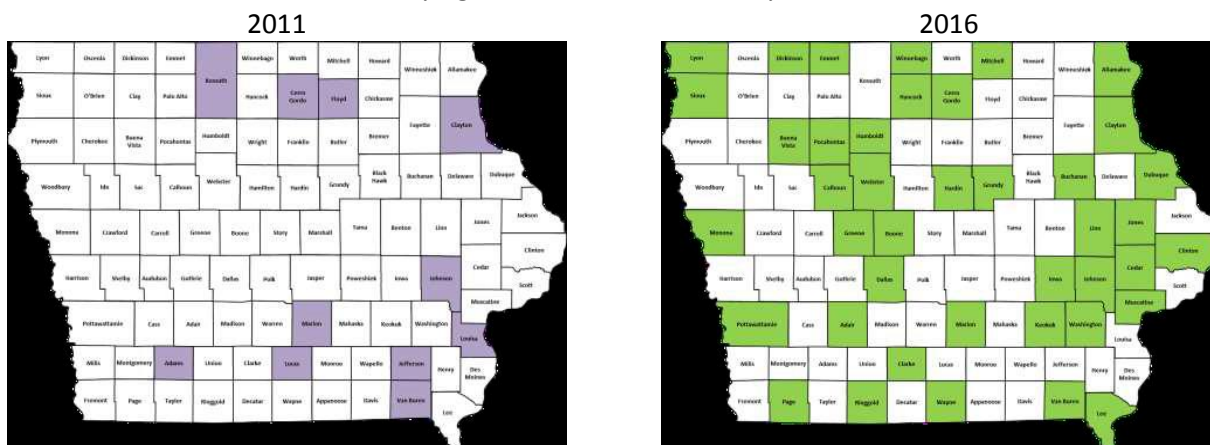
Diabetes is a chronic disease that requires daily management and healthy lifestyle choices to maintain normal blood glucose levels. “Most people with diabetes find its management challenging and a lifelong commitment. But, people with diabetes can live normal and healthy lives and avoid many, if not all, of the complications of diabetes.”<sup>1</sup>

Approximately 211,057 (8.8%) of adult Iowans have been told by a doctor they have diabetes (BRFSS, 2015). “In adults, most diabetes is type 2, which responds well to keeping normal body weight, being physically active, eating a balanced diet and taking medication when needed<sup>2</sup>. Risk factors for diabetes include age, lack of physical activity, a family history of diabetes, certain socioeconomic conditions, obesity and certain races and ethnicities.”<sup>3</sup> In Iowa, the demographic groups that have a higher prevalence of diabetes include: males; Hispanics and White/Non-Hispanics; adults over age 55; individuals having a high school diploma/GED or less; and those with an annual household income of less than \$49,999 (BRFSS, 2015).

Prediabetes is a condition when a person’s blood glucose levels are higher than normal but not high enough to be considered diabetes. Risk factors for prediabetes include having a slightly elevated blood glucose, a history of Gestational Diabetes Mellitus, and a body mass index (BMI)>24. An estimated 9 out of 10 adults with prediabetes don’t know they have it. Further, over 2/3 of Iowa adults report a BMI>25, one of the risk factors for prediabetes (BRFSS, 2015)<sup>4</sup>.

In early 2016, the county local boards of health (LBOH) in Iowa submitted community health needs assessment and health improvement plans (CHNA & HIP). Diabetes was one of the top 10 CHNA & HIP issues identified. In 2011, 11 counties classified diabetes as a need. By 2016, 42 counties named diabetes as a need, as shown on the map below.

Counties Identifying Diabetes as a Community Health Need



The Iowa SIM project, along with collaborative partners, will increase the number of Iowans engaged in healthy behaviors by creating linkages to needed social and medical support.

<sup>1</sup> Iowa Department of Public Health, Iowa Chronic Disease Report Supplement. Diabetes in Iowa on the Increase. 2011.

<sup>2</sup> Ibid

<sup>3</sup> Ibid

<sup>4</sup> Iowa Department of Public Health, Health Promotion and Chronic Disease Control Partnership. Prediabetes in Iowa. 2016.

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## MEASURING PROGRESS

### Goals

The Iowa SIM project and related initiatives will increase the number of Iowans engaged in healthy behaviors by improving mortality, morbidity and reduced long-term cost of care for patients with diabetes as measured by:

- Decreased prevalence of diabetes in Iowa from 8.8% to 8.4% by April 30, 2019. Baseline: BRFSS, 2015.
- Reduced obesity in persons with diabetes from 63.7% to 61.7% by April 30, 2019. Baseline: BRFSS, 2014.
- Reduced tobacco use in persons with diabetes from 25.3% to 24.3% by April 30, 2019. Baseline: BRFSS, 2014.
- Decreased Total Cost of Care for Diabetes: Decrease from \$212.43 to \$206 PMPM by April 30, 2019. Baseline Iowa Medicaid 3M Diabetes, 2015.

### Targets

The following indicators will measure optimal management of diabetes and reduced cost of care to ensure progress toward the goals throughout the SIM project period

#### 1. Outcome measures

- Decrease preventable readmissions (beneficiaries having diabetes, statewide) from 530 to 504 by April 30, 2019. Baseline, Iowa Medicaid 9.29.16.
- Decrease preventable ED visits (beneficiaries having diabetes, statewide) from 803.2 to 763 by April 30, 2019. Baseline, Iowa Medicaid 9.29.16.
- Decrease percentage of patients not having optimal management of diabetes in C3 counties from 26% to 20% by April 30, 2019 as measured by a HgbA1c>9. Baseline: 11.30.16 Iowa SIM Core Metrics Report.

#### 2. System measures

- Improvement in health care system as measured by VBP measures such as VIS: decrease in potentially preventable readmissions by 12% and potentially preventable ED visits by 20% (Medicaid beneficiaries, statewide). Baseline: preventable readmissions (PPR) 6.3% (3569/58,876); preventable ED visits (PPV) 71% (255,422/359,012).

#### 3. Process measures

- Increase the number of hospitals sending ADTs to SWAN Smart Alerting Engine from 25 to 112 by April 30, 2019. Baseline Sept 2016: 25.
- Increase the number Individuals completing National Diabetes Prevention Program from 401 to 700 by April 30, 2019. Baseline July, 2016: 401 (statewide).
- Increase the number of individuals completing state-certified Diabetes Self-Management Education course from 6279 to 7535 by April 30, 2019. Baseline 2015 (statewide): 6279.
- Increase the number of Individuals with housing, food, and transportation needs addressed in C3 counties from 10,603 to 18,700 by April 30, 2019; duplicated. Baseline: February 1, 2016 to January 31, 2017.

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## ROADMAP TO IMPROVE POPULATION HEALTH: DIABETES

The Iowa SIM Project will positively impact health outcomes for diabetes by implementing activities that address: 1) System-level Care Coordination & Management; 2) Evidence-Based Care and Patient Self-Management and Support; and 3) Linkages to Community-Based Resources to Address Patients' Social Needs.

### I. SYSTEM CARE COORDINATION AND MANAGEMENT

Iowans will see a more coordinated system of care with statewide alignment of metrics, collaborative partners, and identification of policy needs; the use of Health Information Technology (HIT) to support improvement in population health measures; implementation of a common structure and function for local governance of care coordination; and improved capacity and infrastructure of the workforce to support care coordination.

#### A. Statewide Alignment

To assure statewide alignment for evidence-based care and patient self-management, the Iowa SIM program will enhance existing statewide efforts in the areas of data, programs and policy. Innovative processes learned, resources developed, and clinical measures collected during the three SIM model test years will be integrated into the 2021 Community Health Needs Assessment & Health Improvement Plan process, when possible to sustain interventions beyond the SIM project period. The Iowa SIM team will seek to address payment barriers that limit attendance to evidence-based programs or do not align with national guidelines.

##### 1. Alignment of Priority Areas and Metrics

Local boards of health and their community partners complete the Community Health Needs Assessment & Health Improvement Plan (CHNA & HIP) process every five years in each of Iowa's 99 counties. The most recent CHNA & HIP submission was February 29, 2016. The top ten needs identified in the 2016 CHNAs include diabetes, tobacco and obesity; as well as the social determinants of health issues of transportation, and mental and oral health access.

CHNA&HIPs are one of five data sources used to determine critical needs in Healthy Iowans, Iowa's State Health Improvement Plan. IDPH SIM staff will submit and commit to reporting on the progress of SIM goals and accountability targets that align with the critical needs identified.

Innovative processes learned and resources developed during the three SIM model test years will be integrated into the 2021 CHNA & HIP process to sustain interventions, especially community-clinical linkages, beyond the SIM project period. Assessments and interventions implemented during the three SIM model test years that address the social determinants of health will be integrated into the 2021 CHNA & HIP process to enhance existing data sources and provide action items for communities. In addition to adding social determinants of health measures, the clinical indicators from the SIM core metrics will enhance Healthy Iowans.

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*Detailed population health activities for AY3 are included in Section III of Operational Plan. These Iowa SIM activities:*

- Assure shared responsibility of health improvement plan activities between local public health and hospitals in Community & Clinical Care (C3) regions
- Add documents and tools developed by SIM to the CHNA & HIP resource list
- Share indicators collected through the SIM core metrics and the C3s to inform 2021 Healthy Iowans process

### 2. Multi-departmental Engagement and Coordination of Efforts

#### *IDPH Programs*

Smoking is a risk factor for Type II Diabetes and this behavior complicates control of the disease. IDPH SIM staff members routinely communicate with staff members from the IDPH Division of Tobacco Use, Prevention and Control. Information is forwarded from weekly tobacco updates to C3 regions. IDPH staff members facilitate communication between the SIM C3s and the local Tobacco Partnerships to assure collaboration and prevent duplication. Aggregated Quitline referral data are provided from the Division of Tobacco Use, Prevention, and Control to the SIM staff so the C3 regions may enhance referral networks and feedback loops.

The IDPH 1<sup>st</sup> Five Program staff and the IDPH SIM staff meet frequently to assure the 1<sup>st</sup> Five program referrals and the SIM C3 referrals for needs related to social determinants of health are coordinated locally. The 1<sup>st</sup> Five model supports health providers in the earlier detection of social-emotional and developmental delays and family risk-related factors in children birth to five and coordinates referrals, interventions and follow up (<http://idph.iowa.gov/1stfive>). Currently, two of the six C3 regions are 1<sup>st</sup> Five Program implementation sites.

IDPH SIM staff members meet routinely with a variety of programs in an effort to reduce preventable Emergency Department visits. For example, the IDPH SIM staff is collaborating with the Office of Disability, Injury & Violence Prevention staff members to inform the C3 regions of local falls prevention programs. Additionally, communication is occurring with the oral health team within the Bureau of Oral and Health Delivery Systems. Funding for the oral health programs is through the HRSA Title V Block grant, CDC Oral Disease Prevention Program, ISmile state appropriations, among others.

The CDC 1305 Diabetes Program provided a training opportunity for implementing a diabetes self-management education (DSME) program and the National Diabetes Prevention Program (NDPP). The IDPH SIM team forwarded the training announcement to the SIM Community Care Coalition (C3) awardees. Three organizations located in SIM C3 counties had representation at the training. The Iowa SIM team will continue to promote future trainings and resources provided through the CDC 1305 Partnership to the C3 regions.

The Iowa SIM program also routinely communicates with the nutrition and physical activity staff members of the CDC 1305 grant. The SIM C3 communities having

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community-based nutrition and physical activity tactics in their action plan are notified as training opportunities or resources by the 1305 program.

Coordination among IDPH programs related to diabetes is essential for producing appropriate supports for prevention and early intervention.

### *Multi-Sector Stakeholders*

The IDPH SIM staff members meet routinely with the DHS Mental Health Redesign staff to assure coordination with that referral program. In addition, the Iowa SIM team provides updates to the Iowa Mental Health Redesign Regional CEOs who collaborate with the local C3 regions.

IDPH program staff members are included in the development and follow up of the Statewide Strategy Plans that the SIM C3 regions utilize in implementing population-based, community applied initiatives locally. These are multi-sector stakeholder groups that include several statewide associations and organizations and include MCOs, the Iowa Chapter of the American Planning Association, and the Iowa Healthiest State Initiative. State agencies attending statewide strategy plan meetings include the Iowa Department of Education, Department of Human Services, Department on Aging, and the Department of Transportation. Additional information on the Statewide Strategy Plans is found in section II.A of this document.

The IDPH SIM staff also participate in the Active Living Iowa stakeholder group that is facilitated by the IDPH Physical Activity Coordinator (CDC 1305) with participation from the Iowa Department of Transportation, Department of Economic Development, Iowa Healthiest State Initiative and Metropolitan Planning Organizations, and several others.

*Detailed population health activities are included in Section III of the AY3 Operational Plan. The Iowa SIM activities:*

- Convene IDPH program partners routinely
- Coordinate and update statewide strategy plan committees
- Inform C3s of multi-sector partner activities occurring locally

### 3. Identify and Address Policy Needs

The IDPH SIM staff team and the Patient-Centered Health Advisory Council staff are functionally located within the Office of Healthcare Transformation. The Patient-Centered Health Advisory Council serves as a key resource for feedback and recommendations to IDPH, the legislature, and other stakeholders on issues related to implementation of Affordable Care Act initiatives in Iowa. Routine communication occurs between the two initiatives. For example, the Council develops newsletters and issue briefs. The IDPH SIM staff members provide information to include in the documents and assist with distribution.

The Iowa SIM program will research opportunities to improve reimbursement for diabetes self-management and prevention programs. Of 85 State-Certified Diabetes

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Self-Management Programs in Iowa surveyed, 61.9% reported challenges or barriers in securing reimbursement for programming.

*Detailed population health activities are included in Section III of the AY3 Operational Plan. The Iowa SIM activities:*

- Identify barriers to reimbursement of DSME, NDPP, and CDSMP
- Inform payers of reimbursement barriers encountered with DSME, NDPP, and CDSMP implementation
- Investigate opportunities for population health measure(s) addressing diabetes to be included in VBP discussions

### B. Aligning Population Health Measures to Value Based Purchasing

Iowa is committed to develop Value Based Purchasing (VBP) strategies that align across payers and have statewide reach so that SIM activities have the greatest reach and improve the care for all Iowans. Ingrained in the work of SIM, is a goal to both increase the participation within VBP arrangements (number of providers and number of covered lives) and increase the intensity (increase financial risk and reporting of quality) of those VBP contracts in Iowa. These efforts will seek to align with the Medicare Access and CHIP Reauthorization Act (MACRA) to be a state that offers an Other Payer, Advanced Alternative Payment Model (A-APM) system to providers by 2019.

To achieve an A-APM in Iowa as a result of national payment reform, the collection of clinical quality measures (in addition to the administrative measures from the VIS) is a new component to the definition of quality. Iowa is in the early stages of implementation to identify infrastructure and measures that are comparable to the Merit-Based Incentive Payment System (MIPS) that could be used in an A-APM structure. Measures that are currently being collected as a part of the Iowa SIM program could potentially serve as candidate measures in a measure set identified for the future A-APM. Details related to the Payment Model can be found in the Operational Plan Section B.2.a. More details on the infrastructure planning can be found in the HIT section of this document as well as under Service Delivery Model and Payment Model in Section B.

IDPH will facilitate a Health IT workgroup to assess the current Health IT infrastructure to support the collection and submission of clinical quality measures. Additionally, the group will identify the core set of CQMs to link to VBP, and a subset of CQMs for Medicaid to test submission during SIM AY3.

For AY3, the C3 contracts will introduce risk based on performance. This contract requirement will expose community based organizations to upside/downside risk, related to performance of community referral processes to community-clinical programs and improvement in provider clinical quality measures.



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*Detailed population health activities are included in Section III of the AY3 Operational Plan and the SIM Health IT Work Plan. The Iowa SIM activities:*

- Identify and build specific workgroups through the Healthcare Innovation & Visioning Roundtable that will determine specific, new quality measures to be used in statewide VBP efforts
- Identify requirements of the A-APM program from final rules (CQMs, CERT Technology minimums, financial risk minimums, etc.)
- Establish a contracting framework, carried out by the MCOs that both aligns with Wellmark on quality and with MACRA on A-APM requirements
- Establish an aligned statewide definition of quality healthcare linked to VBP strategies through the Health IT Workgroup.
- Expand the current method to collect and report back quality results to healthcare systems and health plans to include clinical quality measures through the Health IT Workgroup
- Provide a glide path for all providers and health systems to aggressively transform into value-based organizations that get paid for quality and value
- Collaborate with Wellmark on a plan toward an aligned A-APM model for Iowa providers
- Identify path to submit Other Payer A-APM status by 2019 so Iowa Providers have ability to achieve QP status and earn a 5% Medicare Bonus

### C. Health Information Technology

#### 1. Iowa Health Information Network (IHIN)

With a connection to the IHIN, there is ability to seamlessly access information available through the IHIN within a provider electronic health record. The direct secure messaging functionality within the IHIN gives the ability to send and receive secure messages between providers using the IHIN portal. To facilitate care coordination, the Iowa SIM project will promote connection to and use of the IHIN for healthcare organizations within Community & Clinical Care (C3) regions. Additionally, the integrator organization (as defined through the Accountable Communities for Health model) within the C3 regions will be required to connect to the IHIN to initiate and close the referral loop with community-based organizations.

*Detailed population health activities are included in Section III of the AY3 Operational Plan. The Iowa SIM activities:*

To maximize the IHIN to support care coordination the Iowa SIM project will:

- Incorporate participation recommendations for Community & Clinical Care (C3) contractors
- Provide technical assistance to the C3s and Accountable Care Organizations (ACOs) and the associated clinics on effectively utilizing the query and direct secure messaging functions of the IHIN.

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## 2. Statewide Alert Notification System

The Statewide Alert Notification (SWAN) system was developed in collaboration with Informatics Corporation of America (ICA) in year one of the Iowa SIM project to assist Primary Care Providers (PCPs) in coordinating care of their patients by facilitating notification of inpatient and ED discharges.

IDPH eHealth staff partnered with hospitals statewide to start sending inpatient admission and discharge and emergency department discharge (ADT) information to the Smart Alert Engine. These ADT's then create alerts that will be sent to the Iowa Medicaid ACO's and MCO's. In order to assure efficient coordination of care following discharge and ultimately decrease readmissions, alerts will be sent to the ACO's daily and ultimately in real time. Sending ADTs will further support the coordination of care by informing ACO's and PCP's of patients visiting hospitals outside of their network.

As of September 30, 2016, 25 hospital systems are sending ADTs to the Smart Alert Engine, 11 hospitals are in the review phase, and all five Medicaid ACO's are prepared to receive alerts.

Eligibility files are being received from three of the Medicaid ACO's and MCO's and plans are underway for all ACOs and MCOs to receive alerts. This will allow each organization to determine who from their attributed population of patients they would like alerts to be sent.

Success stories and lessons learned will be shared broadly to engage additional hospitals and enhance the use of alerts by ACOs. Benefits of the SWAN will be communicated to other payers to encourage future participation in the system.

The ADT's received will continually be monitored and modified to ensure ACO's are being alerted on the events which are most important and useful. Monthly meetings for SWAN user groups will be held to share best practices and identify adjustments needed to make the alerts more effective.

*Detailed population health activities are included in Section III of the AY3 Operational Plan with Success Stories shared in Section B.2.b. The Iowa SIM activities:*

To maximize the use of SWAN alerts for system care coordination and management, the Iowa SIM project will:

- Provide continuous outreach to hospitals to send ADT alerts through webinars and conference presentations
- Engage MCOs in communicating with hospitals the benefits of sending ADTs
- Incorporate participation requirements for Community & Clinical Care (C3) contractors

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- Work on process improvement with the 5 Medicaid ACO's and offering technical assistance to ensure they are receiving the alerts most useful to them and have the people and process in place to use the alerts successfully

### 3. Local Care Coordination IT Systems

The C3s are working to build infrastructure to support healthcare reform that requires the ability to communicate health and social needs between providers and community resources. Of the six C3 organizations, three are currently using different care coordination software systems with varying degrees of integration into other health data systems, such as electronic health records or other care coordination software. The three IT systems being used include TAVHealth, Champ software, and Salesforce.

*Detailed population health activities are included in Section III of the AY3 Operational Plan. The Iowa SIM activities:*

- Require C3s to utilize a self-selected IT system to support community care coordination referrals
- Strongly encourage C3s to use the direct secure messaging function of the IHIN to ensure closed loop referrals.
- Identify and provide resources, as they become available, to C3s that provide ideas and guidelines for information sharing between the health care delivery system and community-based organizations
- Communicate routinely with other state initiatives using similar IT systems

### 4. HIT Infrastructure to Support Performance Improvement:

The IHC data base includes a "SIM Portal" which is specific for each of the SIM C3s. The portal integrates data from multiple sources reflective of population health efforts, patient care, and quality improvement. The data from the sources in the bulleted list below is aggregated, analyzed and funneled into individual C3 dash boards. The reports resulting from the dash board data allow SIM communities to align program plans and execute activities. IHC Quality Improvement Advisors assist C3s with process improvement tactics to ensure clinical care transition and community care coordination.

*Detailed population health activities are included in Section III of the AY3 Operational Plan. The Iowa SIM activities:*

- C3's will complete a Quality Improvement work plan
- IDPH will submit SDH and Iowa Quitline referrals from C3s
- IME will report potentially preventable hospital admissions and ED visits (3M/VIS)
- Hospitals and clinics within C3 regions will report clinical quality measures (NQF)
- IHC will analyze data and provide process improvement TA to the C3s

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### D. Common Structure and Function of Local Governance for Care Coordination

Community and Clinical Care (C3) Initiatives are multi-sector groups of stakeholders implementing innovative strategies and referral processes to meet the clinical and social needs of a defined population through person-centered, coordinated care across a range of providers. The C3s have two primary functions: 1) addressing social determinants of health through care coordination; and 2) implementing population-based, community-applied interventions related to the Iowa SIM Statewide Strategies. These initiatives are intended to enhance care coordination and transitions for both providers and patients by identifying population risks and addressing barriers to health such as social determinants by connecting patients (and providers) to community resources; and, develop and/or implement strategies to address diabetes.

A C3 should be “invisible” to a citizen or patient yet benefit the patient by providing a coordinated local system of care. The elements of the foundation for Accountable Communities for Health will be seamlessly incorporated into existing structures of the participating stakeholders.

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## 1. Accountable Communities for Health Model

The structure & function of a C3 includes all of the Elements of an Accountable Community of Health (ACH) as outlined in Table 1.

TABLE 1. Common Elements of Accountable Communities of Health and the Community & Clinical Care (C3) Initiative

Common Elements of Accountable Communities of Health (ACH)	Iowa C3 Model: Structure and Function
Shared vision & goals among partners	
Ability to perform basic financial and administrative functions	Applicant Organization
Integrator Organization:	Community-based organization like local public health to convene partners, carry the vision of the C3, build trust among collaborative partners, convene meetings, recruit new partners, shepherd the planning, implementation, and improvement efforts of collaborative work, and build responsibility for these elements among collaborative members
Established Governance Structure	Steering Committee
Multi-sector Partnerships	Community Care Coalition
Sustainability Planning	Utilize supporting Health IT Remove policy and regulatory barriers, Develop local commitment & long-term framework
Identified community engagement activities/interventions	Utilize community-based care coordinators to provide community-clinical linkages & link to social services & supports
Population-based Prevention Activities	Implement tactics from Statewide Strategy Plans covering clinical, innovative patient-centered care, and community-wide health.

The table above lists the common elements of the ACH framework in black lettering. The C3 requirements that align with the ACH elements are listed in red. The C3 requirements to align with the ACH elements are further detailed in the attached C3 Request for Proposals (RFP).

IDPH is contracting with the Iowa Healthcare Collaborative (IHC) to provide Technical Assistance (TA) to Iowa's C3s in the form of training, provider education, communications, data support and performance improvement support services. The TA includes evidence-based quality improvement resources, and skill building deliverables that detail the processes for care transition for communities and providers.

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*Detailed population health activities are included in Section III of the AY3 Operational Plan. The Iowa SIM activities:*

The following is menu of available technical assistance and resources provided to the C3s by IHC and IDPH:

- Web-based communication platform, facilitating information exchange throughout SIM communities
- SIMplify monthly newsletter
- Resource library with materials pertinent to community initiatives and clinical practice
- Data collection portal and reporting systems, centralizing access to SIM communities reporting metrics
- Educational provisions, statewide conferences, regional workshops, virtual education and training sessions
- Consulting offered by content experts, academic advisors, and healthcare practitioners
- On-site visits to address program and community needs, assist with process improvement and interpret data reports
- Collection and reporting of inpatient metrics related to SIM goals
- Community Scorecards to align community and health systems improvement
- Physician/Clinician Engagement strategy and tools designed to advance clinicians in the Quality Payment Program (QPP)
- Clinic to community care transition flowcharts to guide clinician referrals for patients with social needs within a community
- Provision of coalition-building resources; administrative and subcontract oversight; social determinants of health resources; diabetes, tobacco and obesity resources; CHNA & HIP alignment and execution; and information on potential roles of public health using the chief health strategist functions.

### 2. Capacity and Infrastructure: Workforce

#### *Background*

Preparing the delivery system for payment reform requires a strong workforce within the healthcare delivery system and the community resources that will support providers and ensure their success in a value-based payment system. There are many existing initiatives to address recruitment and retention of primary care providers in Iowa.

Iowa currently does not have a standardized training and certification for community-based providers such as community care coordinators and community supports.

#### *Existing Workforce Initiatives in Iowa*

IDPH has several initiatives to address access to healthcare through recruitment and retention in the healthcare workforce. Several programs, such as the Primary Care Recruitment and Retention Endeavor (PRIMECARRE), Delta Dental Loan Repayment Program, Mental Health Professional Shortage Area Program (MHPSAP), and the

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Primary Care Office, cover providers in medical, dental, and mental health fields, and use loan repayment and other incentives to increase access in provider shortage areas. The Iowa Direct Care Workforce Initiative is working to define direct care worker roles and training needs.

The University of Iowa, College of Public Health Rural Policy Research Institute submitted an Iowa Health Workforce Program Analysis report to the Iowa Department of Public Health, Bureau of Oral and Health Delivery Systems. The executive summary and full report may be found at <http://idph.iowa.gov/ohds/rural-health-primary-care/resources>

IDPH released a competitive Request for Proposal (RFP) and selected the Center for Health Policy and Research in the University of Iowa College of Public Health to build on the findings of the environmental scan completed by IDPH to better understand efforts happening outside of state government to inform future healthcare workforce activities in Iowa. The Center for Health Policy and Research will be conducting an environmental scan to identify data sources in the state to track workforce and lead to identification of which professions are potentially in shortage. As a part of this scan, a statewide summit involving key stakeholders will be convened. Recommendations from the successful applicant selected through this RFP process will inform further activities and planning to improve and support the healthcare workforce in Iowa.

Training for Community Health Workers has been developed by the Iowa Chronic Care Consortium, however there are not recognized roles or certification for CHWs in Iowa. Until there is a state-level definition, individual healthcare provider organizations must identify the roles and training for the community-based health workforce

*Detailed population health activities are included in Section III of the AY3 Operational Plan. The Iowa SIM workforce activities:*

- Prepare Primary Care Providers for a Value-Based Payment System  
The Iowa Healthcare Collaborative will provide training to primary care providers in hospitals and clinics to prepare them to be successful in a value-based payment system. Providers will be educated on how upcoming payment reform legislation will impact their practices, and trained in how to keep their attributed patient panel healthy through person and family engagement, medication safety and effectiveness, care coordination, and the use of existing community resources to address social determinants of health.

To ensure Healthcare Systems Performance Improvement (HSPI) at the community level and within Accountable Care Organizations (ACO), IHC will also work with the C3s' local hospital/clinic providers and ACOs to prepare for health transformation and system changes through quality and process improvement. IHC will use successful TA strategies that crosswalk with the IHC Transforming Clinical Practice Initiative (TCPI) and the IHC HIInnovation Transition programs. HSPI target measures will focus Local and State/IHC activities that feed quality improvement and process change.

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In addition to the work with the C3 contractors, the SIM Learning Communities will provide statewide training to providers and community stakeholders on payment reform. The Iowa SIM 2017 Operational Plan provides detail on HSPI milestones and timelines.

- Ensure Training and Certification for Community-Based Care Coordinators

A coordinated system of care is an integral component of the Iowa SIM initiative and is a primary strategy to support providers in a value-based payment system. Prioritizing training and standardization of the role of community-based care coordinators within the C3s will allow the Iowa SIM initiative to test the most effective use of community-based care coordinators. The community-based care coordinator may be located within a hospital, clinic, or community organization, and must fulfill the following roles:

1. Work with clinical care coordinators in the healthcare system
2. Coordinate services and community resources to address social determinants of health
3. Ensure a complete referral feedback loop

Community Care Coordinators are required to complete the Options Counselor training through the Iowa Department on Aging's Life Long Links program. This training is designed for individuals assisting the elderly in finding resources and using the Life Long Links website. Additional training will be provided based on the outcomes of the environmental scan and workforce summit.

- Align Community Care Coordinator Roles with Iowa's Healthcare Workforce Initiatives

Iowa SIM staff will remain engaged in discussions about the healthcare workforce. Staff from the Office of Healthcare Transformation are involved in the Direct Care Workforce Initiative, and will continue to communicate with the IDPH SIM team regarding Iowa workforce initiatives.

## II. EVIDENCE-BASED CARE and PATIENT SELF-MANAGEMENT AND SUPPORT

Learning how to manage diabetes is very important to those who have the condition to keep it from leading to deteriorating health. Preventing and managing co-occurring conditions and monitoring care during health care transitions are important functions of the healthcare delivery system and community-based organizations.

Diabetes also impacts healthcare utilization and costs. In the Managed Care Digest Series: Type 2 Diabetes Data Brief 2016, Sanofi reports emergency department utilization and 30-day readmissions for individuals with Type 2 Diabetes using any insulin product in the Midwest Region were 16.9% and 18.5%, respectively. Medication adherence for Iowa Medicaid beneficiaries with diabetes and having continuous eligibility in 2015 was estimated to be 45.37% (Iowa Medicaid Enterprise, 2015). Further, the Iowa Medicaid Enterprise states that Iowa Medicaid beneficiaries with diabetes have a 2.5 times higher per member per month cost



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compared to the general Medicaid population. A report by Kaiser Family Foundation (2012) indicates high costs for Medicaid beneficiaries having diabetes may be due to high utilization rates for office visits, filled prescriptions and inpatient stays<sup>5</sup>. A coordinated, closed loop referral system across multiple healthcare settings is needed to assure positive health outcomes and improvement in the total cost of care for diabetes.

### A. Indications for Referral and Treatment Guidelines

#### *Statewide Strategy Plans*

The Iowa Department of Public Health and the Iowa Healthcare Collaborative have convened several multi-sector stakeholder groups to develop Statewide Strategy Plans. The topics covered in these plans include Diabetes, Obesity, Tobacco, Medication Safety and Effectiveness, and Care Coordination, as well as several others. Additionally, Statewide Strategy Plans are currently being developed for Social Determinants of Health and Person and Family Engagement. All of the plans include a variety of tactics addressing several levels of the Center for Disease Control (CDC) and Prevention's Health Impact Pyramid including direct services, group education, promotion, policy, systems and environmental level changes. The Statewide strategy plans are posted to the IDPH SIM website at <http://idph.iowa.gov/SIM>.

Several of the tactics from the Statewide Strategy Plans are being implemented through other IDPH and collaborative partner programming, such as the IDPH CDC-funded 1305 program and the Iowa Healthiest State Initiative. The SIM will increase the intensity and geographical spread of the tactics contained in the Diabetes and other Statewide Strategy Plans through the: 1) C3 "population based, community applied" interventions and 2) promotion of tactics to communities identifying diabetes as a need in their Community Health Needs Assessment and Health Improvement Plans (CHNA &HIP). Tactics from the other Statewide Strategy Plans, such as Medication Safety and Effectiveness and Care Coordination, will be used to provide additional detail on how to implement the interventions included in the Diabetes Statewide Strategy Plan. The Iowa SIM is designed to deliver the most significant impact possible to Iowans in the remaining, abbreviated two-year project timeline. This targeted approach will "move the dial" on the core statewide evaluation metrics and position Iowa's healthcare system to thrive in the midst of system transformation.

#### *National Guidelines*

The American Diabetes Association<sup>6</sup> recommends biannual Hemoglobin A1C (Hgb A1C) testing, and cardiovascular screening that includes a periodic lipid profile, routine blood pressure screening, and daily aspirin therapy if not contraindicated. Annual retinal

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<sup>5</sup> Kaiser Family Foundation. Medicaid and the Uninsured: The Role of Medicaid for People with Diabetes. November, 2012. Retrieved January 30, 2017 from

[https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383\\_d.pdf](https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf)

<sup>6</sup> American Diabetes Association. Standards of Medical Care in Diabetes 2016.

[http://care.diabetesjournals.org/content/suppl/2015/12/21/39.Supplement\\_1.DC2/2016-Standards-of-Care.pdf](http://care.diabetesjournals.org/content/suppl/2015/12/21/39.Supplement_1.DC2/2016-Standards-of-Care.pdf)

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screenings and foot exams are also recommended. Additional foundations of care include routine screening and applicable follow up referral for nutrition and physical activity, tobacco use, psychosocial issues, and diabetes self-management education (DSME).

“Risk for developing pre-diabetes and type 2 diabetes is higher if a person:

- is overweight or obese;
- has a family history of type 2 diabetes;
- is age 45 or older;
- is not physically active;
- had diabetes while pregnant; or
- is African American, American Indian, Hispanic, Asian American, or Pacific Islander.”<sup>7</sup>

To reduce the incidence and improve the management of type 2 diabetes, screening recommendations and referral sources will be provided to primary care providers. The IDPH SIM staff, in collaboration with IDPH Health Promotion and Chronic Disease Partnership (CDC 1305) and Telligen, developed a flowsheet that includes indications for referral to evidence-based diabetes programs<sup>8</sup>. The referral flowsheet is found in Attachment I.

Indications for referral for pre-diabetes will be guided by The American Medical Association and the Centers for Disease Control and Prevention’s provider toolkit, Prevent Diabetes STAT (Screen, Test, Act Today).

To assure consistent implementation of evidence-based tactics to prevent and manage diabetes, the Iowa SIM project will:

- Develop and update tactics included in the Statewide Strategy Plans, in collaboration with multi-sector partners, to provide a coordinated effort in addressing diabetes and co-occurring conditions.
- Provide tactics included in the Diabetes Statewide Strategy Plan to counties indicating diabetes as a priority in the CHNA & HIP. See attached C3 RFP.
- Prioritize interventions in C3 regions to individuals having diabetes with a Hgb A1c>9 and individuals at risk for developing diabetes or pre-diabetes. See attached C3 RFP.
- Provide evidence-based resources, toolkits, and national screening and referral recommendations for diabetes, obesity and tobacco to C3 regions. (IHC and IDPH)
- Deliver technical assistance to C3 communities to improve processes within the healthcare delivery system to identify target populations and improve referral systems. (IHC)
- Collect NQF measures in C3 regions for diabetes and co-occurring conditions to guide performance improvement processes. (IHC and IDPH/C3 Requirement)

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<sup>7</sup> Iowa Department of Public Health, Health Promotion and Chronic Disease Control Partnership. Prediabetes in Iowa. 2016.

<sup>8</sup> Powers et al. (2015). Diabetes self-management education and support in type 2 diabetes: A joint position statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. The Diabetes Educator. Volume XX (X). doi: 10.1177/0145721715588904

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- Deliver technical assistance directed to communities and local clinic/health facilities that empowers patient self-management through: person and family engagement actions and optimal medication safety and effectiveness skills.

### B. Clinical-Community Linkages

Only 64.5 percent of Iowans with diabetes in 2014 reported having taken a class on how to manage it (BRFSS). Diabetes self-management education (DSME) can help individuals gain knowledge and skills to modify their behavior and successfully self-manage the disease.

Type 2 diabetes can be prevented or delayed through the evidence-based and cost-effective National Diabetes Prevention Program (NDPP). Additionally, evidence-based, peer-led programs such as the Stanford Chronic Disease Self-Management Education Program (CDSMP) and Everyone with Diabetes Counts, provide tools for individuals to effectively manage their health conditions.

Community and clinical linkages to four evidence-based group programs will be strengthened in C3 pilot counties through facilitated process improvement cycles that create or enhance existing referral systems. There are currently 90 state-certified diabetes self-management programs in Iowa. For individuals who have recently been through the state-certified DSME program or where payment is a barrier, they may be referred to two other low or no-cost self-management programs. Iowa has a network of trained leaders for the Stanford Chronic Disease Self-Management Program (CDSMP) across the state. Alternately, Telligen is a collaborative partner that provides the Everyone with Diabetes Counts (EDC) to local communities throughout Iowa. The infrastructure for all three of these programs (DSME, CDSMP, EDC) is available and will support increased referrals. Lastly, the National Diabetes Prevention Program, is currently available and will continue to expand in C3 counties. The network for NDPPs has grown significantly in Iowa in the past two years. An informational meeting for starting an NDPP program was held in 2016 with several organizations, including those currently providing DSME programs, in attendance. Three C3 regions implemented NDPPs during SIM AY2. As a result, five of the six C3 regions now have an NDPP infrastructure in place.

Each C3 region will complete an action plan that provides specific steps for developing a more robust referral system to existing DSME, CDSMP, EDC, and NDPP initiatives in their area. Where programs are not available, the IDPH SIM and CDC 1305 staff will provide technical assistance to facilitate implementation of new programs.

Reporting systems for the state-certified DSME program and the CDSMP have been developed and are actively being used by local programs. The EDC program information is available through Telligen. The NDPPs report to a national data base.

IDPH SIM staff, in collaboration with IDPH CDC 1305 and Telligen staff, created a referral flowchart that provides information on the national standards for the indications for referral and descriptions of the four self-management programs. The resource is intended to provide a single reference document for primary care providers that includes indications for

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referral and local program sites. The Diabetes and Pre-Diabetes Referral Flow Chart shown in Attachment I includes a web link to the NDPP and state-certified DSME programs in Iowa.

*Detailed population health activities are included in Section III of the AY3 Operational Plan. The Iowa SIM activities:*

- Increase referrals to the existing 90 state-certified DSME programs in C3 regions (IDPH/C3 Requirement)
- Promote awareness of DSME, NDPP, and peer-led education programs to the healthcare delivery system within C3 regions and statewide. (IDPH and IHC)
- Improve access to NDPP programs in C3 regions. (IDPH and IHC)
- Increase the number of NDPP participants referred that have a fasting blood glucose between 100-125 or a history of gestational diabetes in C3 regions.

### III. LINKAGES TO COMMUNITY-BASED RESOURCES TO ADDRESS PATIENTS' SOCIAL NEEDS

Social systems and physical environmental supports are essential to the success of Iowans' individual efforts to prevent and control diabetes. Research, evidence-base practice, and antidotal observations indicate linking clinics to community service agencies at the clinical entry point through effective referral processes is critical to addressing social determinants of health (SDH). The Diabetes and Care Coordination Statewide Strategy Plans include objectives and tactics to address SDH through established connections to community-based services and promoting referrals of patients with diabetes to community resources. In addition, a Social Determinants of Health statewide strategy plan is in development.

#### *Addressing SDH in C3 Regions*

SDH continues to be a required focus area for the C3s. In SIM award year three, C3s will implement tactics from the Care Coordination and Diabetes Statewide Strategy Plans and ensure incorporation of the healthcare delivery system into community-wide prevention strategies to address SDH. To make certain there is a strong link between clinical prevention, community-clinical linkages, and community-wide prevention, C3s will integrate activities to address SDH into their action plans.

Agencies that provide social support are vital in decreasing health inequities. Also key to health improvement intervention is at the clinical entry point when the patient is assessed for social factors that require intervention. Research, evidence-base practice and antidotal observations indicate linking clinics to community service agencies either electronically or through effective referral processes is critical to influencing the structural determinants and conditions that impede a person's health. The C3's will continue to develop and improve referral systems to address social needs by 1) identifying an integrator organization to link clinical and community-based organizations, 2) implementing a care coordination IT system selected by the community to track referrals between human services agencies, and 3) using the direct secure messaging functionality of the IHIN to receive and close the referral loop with the

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clinical healthcare system. SDH referral data will continue to be collected and reported by the C3s and will populate the IHC SIM Data Portal for analysis. The C3 regions have client cases with documentation that indicate they continue building stronger clinic to community referrals for SDH interventions; that will ultimately improve health treatment results, increase client self-management capabilities, and lower costs.

Each C3 region will complete an action plan that provides specific steps for developing a more robust referral system to address social needs. Because the needs and resources in each community will vary widely, the referral process will be unique to each C3. Two C3 referral examples are found in Appendix D, pages 12 and 13. One example provides a referral process for a patient visiting a primary care provider and the PCP initiating a community-based referral; the second example is for an individual initially accessing services through a community-based organization. The Iowa Healthcare Collaborative will provide technical assistance to continually improve the referral processes that are developed.

### *Addressing SDHs Statewide through HRAs*

AssessMyHealth (AMH) is a secure, web-based health risk assessment that is simple to use. It can be completed over the phone, in-person, and online using paper or electronic means. Reports can be printed by the patient immediately upon completion and a notification is sent to the primary care physician who can then also view the results. The second way SDHs will be addressed in the Iowa SIM project is expanding the use of the Assess My Health (AMH) health risk assessment (HRA) by linking it to the Medicaid Managed Care Organizations contracts. Expansion of the tool to additional payers or to the general population is also being explored. The HRA is a mechanism for individuals to be more engaged in their healthcare. The completed AMH report will inform healthcare providers of the level of patient confidence, as well as the social barriers that may be impeding positive health outcomes.

The aggregated SDH data collected from the AMH completion will identify the most common social needs individuals report and may show the geographical area(s) showing greatest need. The AMH data will be shared with stakeholders to inform decision makers about the SDH needs across Iowa.

For detailed information on the AssessMyHealth implementation, refer to Section 2.b.4 of the Operational Plan and the AssessMyHealth detailed work plan in Section C of the Operational Plan.

### *Detailed population health activities are included in Section III of the AY3 Operational Plan. The Iowa SIM activities:*

The Iowa SIM project will improve linkages to community resources in the C3 regions by:

- Requiring the use of tactics from the statewide strategy plans
- Assigning responsibilities within the healthcare team for care transitions
- Developing and improving referral processes for community care coordination
- Implementing a community care coordination IT tracking system

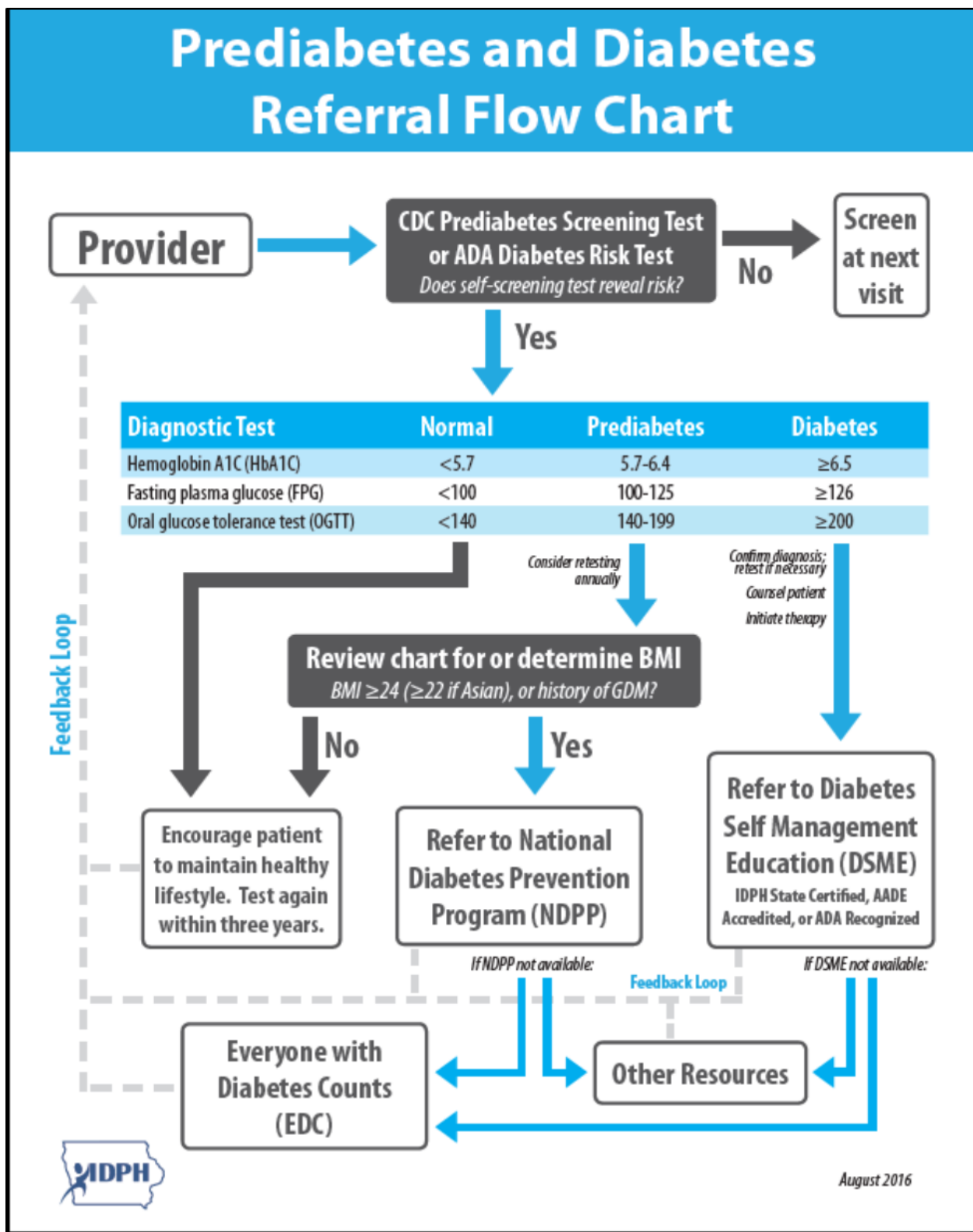
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- Identifying community-based care coordinator(s) to provide community care coordination for SDH, such as access to healthy foods, walkable communities, and transportation resources
- Identifying community-level SDH needs and potential systems changes to improve access to healthcare, transportation including active transportation, housing, healthy foods and basic needs
- Providing resources and technical assistance on using the C3 data dashboards to inform process improvement and increase closed-loop referrals for social needs

The Iowa SIM project will use the AssessMyHealth tool to foster better communication between individuals and their healthcare providers by:

- Creating a process with 3M to modify the AssessMyHealth tool, accept submissions from new sources, and identify reporting procedures.
- Discussing use of AMH with Wellmark and with the Healthiest State Initiative to begin utilization of a HRA by the general population.
- Training SIM TA providers to assist healthcare providers to incorporate the HRA into their workflow

ATTACHMENT I





## Resources

### National Diabetes Prevention Program (NDPP)

The National Diabetes Prevention Program (NDPP) is an evidence-based and cost-effective lifestyle change program for preventing type 2 diabetes among people with prediabetes or at high risk for type 2 diabetes. An estimated 1 in 3 adults in Iowa have prediabetes. NDPP is a year-long, group-based program based on a successful clinical trial. The 2 goals of the program are to lose 5 to 7% of body weight and to increase physical activity to 150 minutes a week. Phase 1 of the class takes place over 6 months and consists of a minimum of 16 sessions meeting weekly for one hour. Phase 2 takes place over the next 6 months and consists of a minimum of 6 one-hour sessions. Some NDPP classes are held in community settings or in other organizations, while others are online. Cost varies by site; contact your local site for more information. For more information about locations in Iowa and patient eligibility, go to <http://bit.ly/NDPPinIA>.

Many adults do not know if they are at risk for type 2 diabetes. Healthcare providers are encouraged to screen any patient of 18 years or older that does not have diabetes. The CDC Prediabetes Screening Test is available at <http://www.cdc.gov/diabetes/prevention/pdf/prediabetestest.pdf> and the ADA Diabetes Risk Test is available at <http://DoIHavePrediabetes.org/>.

### Diabetes Self Management Education (DSME)

Diabetes Self-Management Education is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. The process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards. The overall objectives of DSME are to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life. A physician referral is required. Education is 10 hours and is approved by CMS for reimbursement by Medicare (American Diabetes Association-recognized, American Association of Diabetes Educators-accredited programs), Medicaid (Iowa Department of Public Health state-certified programs), and other third-party payers. For a list of locations in Iowa, go to <http://bit.ly/DSMEinIA>.

### Everyone with Diabetes Counts (EDC) Program

Everyone with Diabetes Counts is a national initiative through the Centers for Medicare & Medicaid Services (CMS). This free program aims to improve health outcomes and reduce issues of health disparities among people with diabetes and prediabetes. Trained educators from Telligen and local community volunteers offer Diabetes Self-Management Education (DSME) throughout Iowa using a model called the Diabetes Empowerment Education Program (DEEP). DEEP incorporates the needs, goals and life experiences of the person with diabetes and is guided by evidence-based standards. The program consists of six classes of approximately 1 ½ hours in length where participants learn how to self-manage their diabetes, the importance of diet, exercise, keeping regular physician exams, managing medications and much more. Classes can be held at churches, community centers, physician offices, hospitals, schools – virtually anywhere someone is willing to host a class. For more information contact Telligen at: [iaqiosupport@area-d.hcqs.org](mailto:iaqiosupport@area-d.hcqs.org) or (515) 440-8600.

### Chronic Disease Self Management Program (CDSMP)

CDSMP, also known as Better Choices, Better Health, is an evidence-based 6-session workshop developed by Stanford University. The peer supported program is designed to help participants self-manage their chronic health conditions by encouraging mutual support of and confidence in the participants' abilities to maintain their wellness; it is not specific to any one disease, but instead addresses a variety of topics that are commonly encountered when dealing with ongoing health conditions. Research has demonstrated that participants who complete the program have experienced better overall health, have more energy and less fatigue, have fewer visits to the doctor and have reduced distress about their health. Learn more at <http://idph.iowa.gov/betterchoicesbetterhealth>.

### References

(2015). Preventing type 2 diabetes: A guide to refer your patients with prediabetes to an evidence-based diabetes prevention program. *American Medical Association*. Retrieved from: [https://www.cdc.gov/diabetes/prevention/pdf/STAT\\_toolkit.pdf](https://www.cdc.gov/diabetes/prevention/pdf/STAT_toolkit.pdf)



Powers et al. (2015). Diabetes self-management education and support in type 2 diabetes: A joint position statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. *The Diabetes Educator*. Volume XX (X). doi: 10.1177/0145721715588904.

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